INTERNATIONAL RESCUE COMMITTEE
SIERRA LEONE PROGRAM

QUARTERLY REPORT

"INFECTION PREVENTION AND CONTROL (IPC) AND SCREENING FOR SUSPECTED EBOLA PATIENTS IN PRIMARY HEALTH CARE FACILITIES IN SIERRA LEONE"

(AGREEMENT NO: AID-OFDA-G-15-00025)

1 JULY – 30 SEPTEMBER 2015

PRESENTED TO:

THE USAID OFFICE OF FOREIGN DISASTER ASSISTANCE

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I. Executive Summary

PROGRAM TITLE:	Infection Prevention and Control (IPC) and Screening for Suspected Ebola Patients in Primary Health Care Facilities in Sierra Leone
PROJECT NO:	AID-OFDA-G-15-00025
AGENCY:	The International Rescue Committee
COUNTRY:	Sierra Leone
REPORTING PERIOD:	1st July – 30th September 2015
GOAL:	Ensure that Sierra Leoneans are able to access health services from trained and protected health workers in all Peripheral Health Units (PHUs) within the context of the Ebola outbreak.
OBJECTIVE(S):	Enable PHUs to remain open, accessible, and providing care, by ensuring screening processes are in place, IPC protocols are followed, and that isolation of suspected Ebola cases occurs.
BENEFICIARIES:	Total targeted: 6,705 (3,729 Health care workers; 2,976 CHWs) Direct; 5,883,302 Indirect IDP beneficiaries: N/A
LOCATION:	All districts of Sierra Leone except for Koinadugu

I. Introduction

In August 2014, the International Rescue Committee (IRC) initiated the creation of the Ebola Response Consortium (ERC) to support the Ministry of Health and Sanitation (MoHS) respond to the EVD crisis through a coordinated approach from non-governmental organizations (NGOs). The full ERC is now comprised of eight member organizations – Action Contre la Faim (ACF), CARE International, Concern Worldwide, GOAL, King's Health Partners, the IRC, Welbodi Partnership and Save the Children – and seven partner organizations – ABC Development, eHealth, Muloma Women's Development Association (MUWODA), Solidarités International, Oxfam, IOM and Médicos del Mundo (MdM). The ERC is currently supporting three key initiatives within the response: 1) support of a national strategy for Infection Prevention and Control (IPC) and screening of suspected Ebola Virus Disease (EVD) cases at 1,096 Peripheral Health Units (PHUs) and 22 government hospitals in the country, 2) support for effective surveillance in 10 districts of the country, and 3) WASH infrastructure upgrades in 128 PHUs, and 22 Hospitals.

The fourth quarter was characterized by marked reductions in Ebola virus disease (EVD) caseload and an increasing geographic confinement of the outbreak, with the number of confirmed cases per month reducing from 27 cases in 4 districts in July to 3 in 3 districts in August. The number of cases rose slightly to 6 in two districts in September. Overall, the number of confirmed EVD cases decreased from 121 cases between April and June to only 36 cases between July and September. Despite notable improvements in surveillance and response capacity, the cases that occurred during the reporting period illustrate the risks that the region will continue to face as the outbreak subsides.

As seen with the EVD case in Bombali (highlighted below), patients with EVD may still present to non-EVD facilities, bringing significant risk of transmission to healthcare workers (HCW), facility staff, other patients and visitors. Since the start of the outbreak, over 400 HCWs have become infected with EVD, leading to fear among HCWs and patients, resulting in reduced availability and utilization of routine essential health services. Maintaining IPC precautions, instituting strict screening and isolation procedures, and determining appropriate modifications for routine services are essential measures for ensuring the safety of the healthcare work force. The ERC is currently implementing a scale- up of IPC mentoring and supervision for all PHUs in the country. The ERC has developed a strategy to reinforce the fundamental IPC approaches in line with initial assessments made of each PHU. Ongoing supportive supervision and on-the-job training, based on identified areas of weakness of health worker IPC and screening practices, will ensure that health workers at PHUs feel confident in continuing to safely provide health care to their communities, and will also be able to take necessary steps to immediately correct any mistakes as they are identified. The ERC will also roll out trainings on newly developed national IPC guidelines out to all PHUs nation-wide.

II. Summary of Activities

Supervisory visits

Between July and September, the ERC partners made 5,371 supporting supervisory visits across all districts. Of these visits, 17.9% (914) were joint visits with the DHMT. The majority of ERC partners reported that supervision findings reveal a mismatch between knowledge and practice among PHU staff. While IPC knowledge and infrastructure levels are quite high, IPC practices are lower. ERC partners continue to emphasize IPC behavioral change during the mentoring and supportive supervision sessions.

Distribution of IPC supplies

In all districts, ERC partners supported the DHMT with the delivery of IPC materials (supplied by the DHMT) to all facilities. During this quarter, all PHUs received one blanket supply of IPC materials including aprons, gowns, elbow gloves, chlorine, rubber gloves, goggles and face masks. Two districts noted that there are no plans for the District Medical Stores (DMS) to supply PHUs with batteries for infra-red thermometers and they are not in stock in the districts. As a result, ERC partners in these districts supplied PHUs with a stock of batteries for infra-red thermometers.

Partners also procured supplies in order to help rebuild screening and isolation areas damaged by heavy rains. Some districts have supplied sets of plastic sheets (tarpaulins) to PHUs to improve the screening areas and isolation units. This supply has enabled PHUs to establish more conducive structures for screening and isolation of suspected EVD cases, as most structures were damaged or destroyed by the rains. Other districts are supplying some PHUs with pieces of corrugated iron sheets and roofing nails to support the reinforcement of their screening and isolation areas. In the next quarter, the communities in the districts will provide the local construction materials.

Community engagement

In all districts, ERC partners engaged with Facility Management Committees (FMCs) and Health Development Committees (HDCs). Engagement of FMCs and HDCs ranged from helping to build screening booths to positioning signposts at the PHUs. In the case of screening stations, the community provided local materials and skilled labor for carpentry units. Communities also provided local materials and labor to construct perimeter fences for PHUs.

The FMC also held meetings to engage community members on issues relating to IPC structures and practice, focusing on how to keep their communities safe and how they can help their PHU win a performance award. The FMC serves as a liaison between the communities and their PHUs and they meet on a monthly basis to discuss issues that are affecting the implementation of IPC in their communities. FMCs take part in the performance award ceremonies in their communities as they help these PHUs carry out environmental cleaning and build permanent structures for both triage and isolation areas for the PHUs.

The involvement of FMCs has been essential, especially in identifying volunteers to work as screeners, as FMCs helped to assuage screeners' dissatisfaction following the reduction of the incentives in August 2015. The ERC technical team decided to reduce incentives in order to ensure the sustainability of the screening activities by bringing the incentives in line with those provided by the MoHS. The FMCs have also been instrumental in facilitating the establishment of waste management systems, including the digging and fencing of waste pits. Efforts to revive FMCs, especially in Maternal and Child Health Posts (MCHPs), has been challenging as many of them have been inactive and are unsure of membership composition. In these cases, chiefs, village heads and youth leaders have been informed about the importance of the committee and the effort to revive them is ongoing. ERC partners also engaged with Village Development Committees (VDCs) and FMCs when introducing IPC Trainers to PHUs. These meetings facilitate community involvement and allow for the opportunity to emphasize the need for robust IPC measures in health facilities and allow for communities to provide feedback about the process.

In Kono, the community called a meeting themselves, without prompting from the ERC partner, after the community learned that a nearby facility in the same chiefdom had won two consecutive performance-based awards. In this meeting, the community discussed setting up proper screening and isolation areas, as well as digging waste pits.

Incentives for best performing PHUs

The ERC partners provided 164 performance based awards in 8 districts between July and September (5 districts did not distribute any performance based awards during the reporting period).

The majority of ERC partners used the criteria below to select PHUs to receive a performance based award:

- **IPC Team Choice Award:** Awarded to the PHU which demonstrates exemplary behavior in IPC or screening practices. This PHU acts as a model to other PHUs. Nominations for the IPC Team Choice Award will be through voting.
- **Best Overall IPC and Screening Practices:** Awarded to the PHU which attains the highest total score on the Quality Assurance (QA) tool.
- **Demonstrated Dedication to Improving the PHU Structure:** Awarded to the PHU which has the highest total score on QA -IPC Structure.

- **Consistent Outstanding IPC Behavior:** Awarded to the PHU which has sustained perfect scores on the QA tool for IPC Behavior over the course of at least four mentoring visits.

Incentives included: wall clocks; towels; packets of soap; thermometer batteries; hand sanitizer; and liquid soap. Other ERC partners chose to award money (250,000 SLL) that was used to buy Veronica buckets, tarpaulin for screening booths, and paid laborers to dig waste pits by the PHU.

In two districts, the DHMT suggested that the 12 best performing PHUs in the district (based on QA tool performance) were provided with: one (1) generator, one (1) wall clock and 300, 000 SLL in cash each. The cash was intended to be used as a startup for the generator and security costs. These awards have motivated other PHUs to improve on IPC measures.

Involvement of community members during the award ceremonies has created healthy competition, not only amongst health staff, but also among catchment communities, thus motivating some previously underperforming PHUs to make greater efforts to improve their IPC practices. Where no performance based awards were given, the ERC has begun the procurement process to provide awards in the next quarter.

Case Studies of IPC Improvements and Innovations

Kenema: In Kenema, the IRC consistently found Blama PHU to be performing poorly during supervisions. There was no isolation area, improper storage of IPC supplies, and poor waste management. As a result, IRC staff focused on this facility for frequent supportive supervisions and on-the-job training with the PHU staff, and visited HDC members, Chiefs, and the FMC. The IRC cited examples from other communities to demonstrate the different solutions used to address the weak performance. These visits led the in-charge, the head of the Blama health unit, to engage his staff in a meeting to discuss these issues. They reached an agreement to use their performance-based financing (PBF) from the MoHS to address the problems. When the health unit presented this to the community, they offered labor assistance. The community and PHU staff constructed an isolation area and toilet, re-organized the drug store, and rehabilitated the incinerator & burning pit.

Bombali: When a motorbike carrying a teenage girl who was bleeding profusely arrived at a clinic in Bombali district on Saturday, the community health aid, Brima Kamara, knew exactly what to do. GOAL had trained Mr. Kamara in IPC practices under this project. Mr. Kamara isolated the 16-year-old patient outside of the Pate Bana Marang health center at about 5:30pm and called for an ambulance. "If I see wet signs in a patient, I know not to touch them. This girl was bleeding from her nostrils and was very weak and restless. She couldn't stand, she couldn't walk. I knew we had to refer her," Mr. Kamara said. As the night wore on and the ambulance had yet to be seen, Mr. Kamara organized for the patient to be transported by two Ebola survivors who reported to the clinic with their survivor certificates. He gave them PPE, facemasks and a referral letter to Mateneh Ebola Treatment Centre, where they doffed and burnt the protective clothing. The patient died soon after, as she had been treated at home for five days before presenting to the health facility. She was confirmed to have died of Ebola. Mr. Kamara and his staff disinfected the PHU thoroughly once the patient had left, but said the event had evoked fear in the community and very few patients had visited since Saturday. "To get rid of Ebola from this district, we need to encourage patients to come back here so we can refer them properly," he said.

EVD Response – Ring IPC in Bombali

Following the confirmed EVD case in Bombali district, GOAL has played a vital role in the response to eradicate the reemergence of EVD in the district and acted as IPC lead for this operation. GOAL worked in collaboration with Center for Disease Control and Prevention (CDC) and World Health Organization (WHO) to implement Ring IPC.

Ring IPC is a strategy used to strengthen capacity to screen, isolate, and notify suspected Ebola cases in healthcare facilities in areas of ongoing Ebola transmission. A response team from WHO, CDC, MoHS/DHMT and GOAL developed a map of 15 PHUs to target within the 'ring' of current potential transmission and infection. As part of

the Bombali Ring IPC response, GOAL delivered buffer stocks of IPC supplies to the 15 PHUs. GOAL IPC Supervisors performed 2-3 PHU visits twice a day in the morning and afternoon to provide necessary support and mentored all screeners and health workers of the PHUs on a daily basis. All 15 in-charges of ring PHUs received training on the new screening tool provided by WHO/DHMT. GOAL continued supplying screening forms as required.

Training of CHWs/TBAs as screeners

The ERC partners trained 1,083 Community Health Workers (CHWs)/Traditional Birth Attendants (TBAs) as screeners during the reporting period, with a total of 2,485 CHWS/TBA engaged in screening by the end of September 2015. All districts have lost screeners after the ERC reduced the incentive from 400,000 SLL a month to 100,000 SLL a month, in order to stay aligned with MoHS hazard pay rates to screeners at other facilities. As a result, the ERC has begun a new round of training in order to replace screeners who have left.

III. Indicator Tracking

Table 2: Objective Achievements for Project by Indicator

Indicator	Unit	Target	Actual Q4		Cumulative		Remark
Health: Health Systems and Clinical Support							
Number of health care facilities supported[1] and or rehabilitated by type (e.g., primary, secondary, tertiary)	Facility	1,096	16		1,117		Many screening stations are being rebuilt after the rains.
Number of health care providers trained by type (doctor, nurse, community health worker, midwife, and traditional birth attendant) disaggregated by sex[2]	Person	6,696	0		6,696		This training refers to comprehensive IPC training.
Number of consultations, disaggregated by sex and age[3]	Person	TBD	M	F	M	F	July and August consultation numbers missing from Port Loko. September consultation numbers missing from Pujehun, Moyamba, Kambia, Bonthe, and Port Loko. There is normally a 1 – 2 month delay before the DHMT receives complete
Under-five			257,877	259,753	735,278	781,700	
Over-five			111,837	297,585	405,282	846,016	

[1] "Support" in this case means setting up screening stations at all of the health facilities.

[2] This training will be rapid training at the PHU level

[3] The ERC will not be able to disaggregate this information to the level of detail normally needed (0-11 months; 1-4 years; 5-14 years; 15-49 years; 50-60 years; 60+ years) as part of this project. The ERC will disaggregate only by under-five and over-five, as well as by sex. Further disaggregation would add a layer of data compilations that would be unfeasible with this number of health facilities

							reporting from all PHUs.
Number and percentage of PHUs per month that require "urgent action" (retraining, etc.) in their Ebola response in terms of their (a) infection prevention and control structure; or (b) infection prevention and control behavior[4]	Facility	25%	a) 17.05% (n=270) b) 26.71 (n=391)		a) 17.05% (n=270) b) 26.71 (n=391)		
Health: Community Health Education/Behavior Change							
Number of CHWs trained[5] and supported (total and per 10,000 population within project area), disaggregated by sex.	Person	3,288	1,083		4,645		Additional CHWs have been trained to replace those screeners who left their posts.
Number and percentage of CHWs specifically engaged in public health surveillance[6]	Person	3,288 (100%)	2,385		2,540		A number of CHW screeners left their positions after their incentives were reduced.

IV. Constraints and Challenges

Screening booths: The rains during the reporting period have damaged many screening structures that were put up as a part of this project. DHMTs and communities are becoming frustrated with building non-permanent structures that are not able to withstand the rains and would rather have semi-permanent or permanent structures built. Some communities have begun providing local materials and labor to build more permanent structures.

Vehicle constraints: There was a nationwide fuel shortage during the reporting period, which particularly affected remote districts and contributed to fewer supervision visits. In addition, the road quality worsened in rural areas (as annually expected) as a result of the rainy season which also lead to fewer visits than normal in some districts. Severe flooding in Western Area and Pujehun also affected the abilities of teams to reach isolated PHUs.

Reduction in screening incentives: This was a significant challenge leading to screeners leaving their posts or failing to follow proper screening procedures. The ERC lowered the incentives for screeners from 400,000 SLL to 100,000 SLL a month in line with MoHS incentive rates, as well as to bring this in line with other CHW incentives. The ERC technical team made this decision in order to ensure the sustainability of the screening practices.

IPC supplies: Many facilities reported stockouts of key items like gynecological gloves and disposable towels, as these items were not in stock in the majority of District Medical Stores. Districts also noted that DMS was not providing (and did not have in stock) batteries for infrared thermometers.

[4] The ERC will also monitor key inventory at each PHU but our partner UNICEF is responsible for stocking and restocking (the ERC will distribute inventory items at each PHU once they are received at district level from UNICEF).
[5] The CHWs/TBAs will be trained to do screening at PHUs
[6] This engagement refers to screenings conducted by CHWs/TBAs.

Availability of PHU staff: PHU staff were frequently unavailable for regular supervision because they had been called to various Ebola response related trainings at the district level.

Screening Practices: CHW/TBA screeners most often forget to screen IPC Supervisors and other people with whom they are familiar when these people enter the PHU premises as the screeners assumed them to be healthy. IPC Supervisors are continuing to emphasize the importance of screening every person who enters the facility.

Availability of DHMT: Frequent engagement of the DHMT in other MoHS assignments such as trainings and staff verification processes hindered planned joint quarterly IPC supervision, as the DHMT has been unavailable to perform this role, thereby threatening the continuation of DHMT support and engagement in longer term IPC supervision.

Waste management system and water supply: Lack of waste management systems and water supply has limited the application of the IPC protocols in PHUs. This is because inasmuch as the health care workers know the right way to dispose of the different types of waste, some lack proper infrastructure such as incinerators, placenta pits, and sharps pits to dispose of the waste. Lack of water has also been a limitation to hygiene practices, such as hand washing and general cleaning and disinfection of the PHU.

V. Activities for the following reporting period

As this project will come to an end on October 31st, 2015, activities will continue under the new OFDA-funded IPC in PHUs grant. The new grant includes the addition of Koinadugu district and will track formal training of CHWs in place of on-the-job training as previously monitored. All other planned activities remain the same.

Planned activities for the next quarter include the roll out of training on new IPC guidelines for PHUs across the country. The ERC is working with the MoHS, UNICEF, CDC and WHO to roll out the next phase of the IPC in PHU project that will start in November 2015. This plan is aligned with the Government of Sierra Leone's (GoSL) Health Sector Recovery Plan. The ERC partners will ensure that all PHU staff are trained on the new IPC guidelines, tailored to the specific realities of PHUs. This training will differ from the previous training as it goes beyond EVD IPC, giving PHU staff more comprehensive IPC knowledge.

Twice-monthly supportive supervision visits will continue to each PHU to monitor and strengthen IPC practices, as will quarterly visits with the DHMT. The ERC partners will continue providing performance-based awards to the top 10 PHUs in each district in order to improve quality and performance. The MoHS is leading the establishment of district team meetings to review program data and prioritize PHUs for support and action. The MoHS is also the process of appointing district IPC Focal Persons within the DHMT. The ERC will distribute screening stations, IPC and Personal Protective Equipment (PPE) supplies on an as needed basis to PHUs. ERC payment of incentives to screeners and community meetings with Health Management Committees will continue for targeted facilities.

VI. Annexes

Screening area and isolation unit in Bunumbu CHC - Peje West Chiefdom, Kailahun district. Established after the supply of plastic sheets (tarpaulin) by Save the Children.

Donation ceremony of IPC Performance Based Awards to DHMT for 12 best performing PHUs in Kailahun district.

A hand washing and screening station at Moyamba Junction CHC.

GOAL area Coordinator and DMO presenting the award for best IPC PHUs during monthly meeting.